Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRISTUS ST ELIZABETH HOSPITAL
C/O HOLLOWAY & GUMBERT
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3916

Respondent Name
TEXAS MUNICIPAL LEAGUE
INTERGOVERNMENTAL RISK POOL

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-1071-01

MFDR Date Received
October 8, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because the patient's condition clearly met the definition of medical emergency, preauthorization was not required . . ."

Amount in Dispute: $33,856.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TML-IRP denied payment because the provider failed to obtain preauthorization for a nine-day in-patient stay. . . . This was submitted as an ER admission, but the billing does not indicate ER charges, nor is it easy to see how a pre-discussed procedure could be an emergency."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2007 to October 18, 2007	Outpatient Hospital Services	$33,856.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
4. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
5. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
6. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

7. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – THIS BILL HAS BEEN AUDITED AND RECONSIDERED. NO ADDITIONAL PAYMENT DUE. PLEASE REQUEST MDR IN ACCORDANCE WITH RULE 133.305. Will continue to deny for no preauthorization
   - 197 – PAYMENT DENIED/REDUCED - ABSENCE OF PRECERTIFICATION/AUTHORIZATION Payment adjusted for absence of precertification/authorization

Findings

1. The insurance carrier denied disputed services with reason codes 197 – "PAYMENT DENIED/REDUCED - ABSENCE OF PRECERTIFICATION/AUTHORIZATION Payment adjusted for absence of precertification/ authorization," and 18 – "THIS BILL HAS BEEN AUDITED AND RECONSIDERED. NO ADDITIONAL PAYMENT DUE. PLEASE REQUEST MDR IN ACCORDANCE WITH RULE 133.305. Will continue to deny for no preauthorization." The provider's position statement asserts that "It is the hospital's contention that the medical treatment provided to the patient was performed on an emergency basis, and that without said treatment, the claimant ran a significant risk that his symptoms would become irreversible placing his health and/or bodily functions in serious jeopardy and/or leading to serious dysfunction of a body organ or part." The insurance carrier replies that "This was submitted as an ER admission, but the billing does not indicate ER charges, nor is it easy to see how a pre-discussed procedure could be an emergency." Former 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, provides that the carrier is liable for all reasonable and necessary medical costs relating to the health care only when the following situations occur: "(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." Former 28 Texas Administrative Code §133.2(3)(A), effective May 2, 2006, 31 *Texas Register* 3544, defines a medical emergency as "the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part." Review of the submitted medical documentation finds that the provider has supported the occurrence of a medical emergency. The Division concludes that the insurance carrier's denial reason is not supported. These services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 808.49. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issue(s) including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
6. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute

involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor's position statement asserts that "Provider requests to reimbursed in the amount of $73,389.72 for th emergency services it provided to this worker' compensation patient." [sic]
- The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	August 9, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.